e. Outgoing Contractor Weekly Shipment of History Updates

The outgoing contractor shall transfer to the incoming contractor, in magnetic tape format, all beneficiary history and deductible transactions (occurring from the date of preparation for shipment of the initial transfer of such history files and every week thereafter) beginning the sixtieth (60th) calendar day following notice of award by *TMA* (until such a time that all processing is completed by the outgoing contractor) in accordance with the specifications in the official transition schedule. See dual operations in Section VIII.C.3.

f. Transfer of Non-ADP Files

The outgoing contractor shall transfer to the incoming contractor all non-ADP files (e.g., preauthorization files, clinic billing authorizations, and tapes which identify catchment areas, microfilm/microfiche files, Congressional and *TMA* completed correspondence files, appeals files, *TRICARE* medical utilization, and administration files) in accordance with the specifications in the official transition schedule and the OPM Part Two, Chapter 3. The hard copies of the Beneficiary History Files are to be transferred to the incoming contractor or Federal Records Center as required by the OPM Part Two, Chapter 3. The contractor shall provide samples and descriptions of these files to the incoming contractor at the Transition Specification Meeting.

g. EOB Record Data Retention and Transmittal

If the contractor elects to retain the EOB data on a computer record, it must, in the event of a transition to another contractor, provide either a full set of microfile records covering the current and two prior years, or, at the Contracting Officer's discretion, provide the data and necessary programs to reproduce the EOB in acceptable form and transfer such data and programs to the successor contractor or to *TMA*. *TMA* shall be the final authority in determining the form and /or acceptability of the data and/or microcopies. (See OPM Part Two, Chapter 1, Section VI.)

h. Outgoing Contractor Weekly Status Reporting

Until all inventories have been processed, the outgoing contractor shall submit a weekly status report of inventories and phase-out activities to *TMA* beginning the twentieth (20th) calendar day following notice of award by *TMA* until otherwise notified by the Contracting Officer to discontinue. This shall be done in accordance with specifications of the official transition schedule.

i. Final Processing of Outgoing Contractor

The outgoing contractor shall:

(1) Process all claims and adjustments identified by the ninetieth (90th) day following cessation of the outgoing contractor's health care delivery. Processing of these claims shall be completed within one-hundred eighty (180) calendar days following the start of the incoming contractor's health care delivery.

(2) Process all correspondence, allowable charge complaints, and incoming telephonic inquiries which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

(3) Complete all appeal/grievance cases which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

j. Correction of Edit Rejects

The outgoing contractor shall retain sufficient resources to ensure correction (and reprocessing through *TMA*) of all health care service record edit errors not later than two-hundred ten (210) calendar days following the start of the incoming contractor's health care delivery.

k. Phase-Out of the Automated TRICARE Duplicate Claims System

The outgoing Contractor shall phase-out the use of the automated TRICARE Duplicate Claims System in accordance with ADP Manual, Chapter 12 and transition plan requirements. (See ADP Manual, Chapter 12, Addendum C and Addendum D, for Transitional Guides for transition requirements.)

4. Phase-Out of the Contractor's Provider Network, *TRICARE* Service Centers, and MTF Agreements

Upon notice of award to another contractor, the outgoing contractor shall provide full cooperation and support to the incoming contractor, to allow an orderly transition, without interruption, of all functions relating to the MTF interface and the establishment of a provider network by the incoming contractor. This shall include, but is not limited to, data relating to on-site service centers, resource sharing agreements, equipment, telephones and all other functions having an impact on the MTFs.

a. Within fifteen (15) calendar days of the Transitions Specifications Meeting the outgoing contractor shall draft and submit in the revised phase-out plan a plan for transition of the MTF interfaces. Resolution of differences identified through the coordination process must be accomplished in collaboration with the Transition Monitor appointed by *TMA* and according to the guidelines in the transition schedule.

b. The outgoing contractor shall allow the incoming contractor unencumbered access to incumbent resource sharing providers for purposes of recruitment, and shall make available to the incoming contractor within five (5) calendar days of a request, copies of all resource sharing agreements in effect as of the date of award. The above notwithstanding, the outgoing contractor will not be required to disclose any information recognized by Federal law and regulation as proprietary. Questionable situations must be referred to the *TMA* designated Transition Monitor for resolution.

c. The outgoing contractor shall vacate the *TRICARE Service Centers (TSCs)* on the fortieth (40th) calendar day prior to the start of health care delivery and will establish a centralized Health Care Finder function, unless otherwise negotiated with the incoming contractor during the Transition Specifications Meeting. NOTE: This section only applies when both the incoming and outgoing contractors have *TRICARE* Service Centers (TSCs).

d. The outgoing contractor will terminate marketing and enrollment activity forty (40) calendar days prior to the start of the incoming contractor's

health care delivery. Any enrollment requests or applications received after the fortieth (40th) day shall be transferred to the incoming contractor.

e. The outgoing contractor will continue to issue prior authorizations for care for which it is financially responsible. However, authorization-related information shall be shared between the incoming and the outgoing contractors to preclude requiring a provider or beneficiary to duplicate the paperwork and other effort related to establishing prior authorizations. The outgoing contractor may issue prior authorizations as late as midnight on the day prior to the end of its health care delivery for inpatient stays that will continue as transitional cases. The Health Care Finders of the two contractors shall interface on the clinical issues of a case where both contractors will, or can reasonably expect to have periods of liability for the same episode of care.

f. The outgoing contractor shall maintain toll-free lines, accessible to the public during the first ninety (90) calendar days of dual operations in order to properly respond to inquiries related to claims processed for services incurred during the period of their respective liability. Beneficiary inquiry lines will continue to be staffed as defined in the contract. In general, the outgoing contractor will be required to maintain adequate toll-free line coverage to ensure that the blockage rate does not exceed the blockage rate on the contractor's most critical private or other government business access line.

E. Instructions for Benchmark Testing

1. General Information

a. Prior to the start of health care delivery a new or incumbent Contractor shall be required to demonstrate the ability of its staff and its automated claims processing system to accurately process *TRICARE* claims in accordance with current requirements through a Benchmark Test. The Benchmark Test is administered by *TMA* personnel. Generally the Benchmark will be completed at least sixty (60) calendar days prior to the start of health care delivery.

b. A benchmark may consist of up to 1,000 in and out of system claims, testing a multitude of conditions. This benchmark may require up to 17 consecutive calendar days at the Contractor's site.

(1) A benchmark is comprised of one or more cycles or batches of claims. When more than one cycle is used, each cycle may be submitted on consecutive days. Each cycle subsequent to the initial one will include new test claims, as well as claims not completed during preceding cycles, including suspended claims. All aspects of claims processing may be tested, e.g., screening, coding, data entry, editing, pricing, etc. The Contractor must demonstrate their ability to execute claims processing functions to include: claims control and development, accessing and updating DEERS in regards to eligibility and enrollment status, calculating cost-shares and deductibles, querying and updating the Central Deductible and Catastrophic File (CDCF), submitting and modifying Health Care Provider Records (HCPRs), submitting and modifying pricing records, issuing referrals and authorizations, applying allowable charge parameters, performing duplicate checking, generating and applying authorization and enrollment data, applying prepayment utilization review criteria, adjusting previously processed claims, demonstrating recoupment and offset procedures and producing the required output (EOBs, summary vouchers, payment records, checks, and management reports). Clerical functions to be

evaluated include correctly coding diagnoses and medical and surgical procedures and accurately resolving edit exceptions. TRICARE Service Center functions to include Health Care Finder, enrollment, and case management functions may also be included in the benchmark. In addition to testing claims processing functions, the benchmark will also test generation and acceptance of Health Care Service Records (HCSRs) for every test claim.

(2) Incoming Contractors are required to participate in a Benchmark Test. Generally, the test will be comprised of approximately 1,000 test claims. Under certain circumstances, however, this number may be reduced at the discretion of the Contracting Officer. An example of circumstances which may warrant consideration by the Contracting Officer to reduce the number of Benchmark Test claims is when an existing *TRICARE* Contractor is awarded an additional contract and the claims processing system proposed for the new contract is the same as the system used for the existing contract and the existing claims processing system has successfully passed a Benchmark Test within the previous 12 months. The 12 months will be calculated from the calendar month in which the previous benchmark test was performed.

(3) A benchmark of a current Contractor's system may be administered at any time by *TMA* on instruction by the Contracting Officer.

c. All Contractor costs incurred to comply with the performance of the Benchmark are the responsibility of the Contractor.

2. Conducting the Benchmark

a. The Benchmark Team will be comprised of up to 12 people depending on the scope of the benchmark and the volume of claims to be tested.

b. The amount of time a Contractor will have to process the Benchmark Test claims and provide all of the output (excluding HCSRs) to the Benchmark Team for evaluation will vary depending on the scope of the benchmark and volume of claims being tested. As a guide, the following table is provided for Contractor planning purposes:

NUMBER OF BENCHMARK CLAIMS	NUMBER OF DAYS TO COMPLETE PROCESSING
UP TO 100	1-2
UP TO 500	2-4
UP TO 1000	4-7

(1) The Contractor will be informed at the pre-benchmark meeting (see E.3.a.) of the exact number of days to be allotted for processing the benchmark claims and providing all of the output (excluding HCSRs) to the Benchmark Team for evaluation.

(2) When a weekend falls within the number of days allotted to complete claims processing and to provide all of the output for evaluation, the Contractor will have the option of working the weekend days and having them count in the total

number of days allotted to complete processing or not working the weekend and having the count resume on the following Monday. The decision as to whether a weekend will be worked shall be agreed upon at the pre-benchmark meeting.

c. The Benchmark Team will provide answers to Contractor's written and telephonic development questions concerning the benchmark claims and will evaluate the Contractor's output against the Benchmark's Test conditions.

d. The Benchmark Team will require a conference room that can be locked with a table(s) large enough to accommodate up to 12 people. A key to the conference room is to be provided to the Team Leader. The conference room must also be equipped with two telephones with access to internal and outside telephone lines.

e. The Contractor shall provide a complete, up-to-date Operations Manual, ADP Manual, Policy Manual and *TRICARE* Regulation, a complete set of current ICD-9-CM diagnostic coding manuals, the currently approved CPT-4 procedural coding manual, the most recent applicable Red or Blue Drug Book, whichever is used by the Contractor, and explanation of their EOB message codes, edits, and denial reason codes, and any overlays required to evaluate EOBs, checks or summary vouchers.

f. The Contractor shall provide a minimum of three (3) terminals in the conference room with on-line access to: provider files, including the contracted rate files for each provider; pricing files (area prevailing and CHAMPUS Maximum Allowable Charge pricing); DEERS; CDCF; authorization files; referral files; and enrollment files. The Contractor's requirements for issuing system passwords for members of the Benchmark Team will be discussed at the pre-benchmark meeting.

g. The Contractor shall provide a stand alone Hewlett-Packard Laserjet or compatible (series IIID or later) laser printer with preferably four (4) or more megabytes of memory but no less than two (2) megabytes.

h. The Contractor shall provide an organizational chart and personnel directory including telephone numbers. A listing of the Contractor's staff involved in performing the benchmark by function (e.g. data entry, development, medical review, etc.) is also required.

3. Procedures

a. Approximately 90 to 120 days prior to the start of health care delivery, representatives from *TMA* will meet with the Contractor's staff to provide an overview of the Benchmark Test process, to receive an overview of the Contractor's claims processing system, to collect data for use in the benchmark, and to discuss the dates of the test and information regarding the administration of the Benchmark Test. This pre-benchmark meeting will be conducted at the Contractor's claims processing site. Provider and beneficiary data, to include enrollment forms, physician referrals, and authorizations will be coordinated at the pre-benchmark meeting to ensure that all files are adequately prepared by the Contractor prior to the benchmark.

b. On the first day of the Benchmark Test, a brief entrance conference will be held with the appropriate *TMA* and Contractor personnel to discuss the schedule of events, expectations and administrative instructions.

c. During the Benchmark Test the Contractor will be required to process the claims and provide *TMA* with all output, including EOBs, summary vouchers, suspense reports, checks and relevant supporting reports such as system printouts, claims histories, procedure code listings, etc. The checks and EOBs may be printed on plain paper, with EOB and check overlays.

d. The Contractor shall provide output to the Benchmark Team for evaluation as the claims are processed to completion. The specific schedule for claims processing and the procedures for providing the output to the Benchmark Team will be discussed with the Contractor at the pre-benchmark meeting.

e. *TMA* will compare the Contractor's output against the Benchmark Test conditions for each claim processed during the test.

f. During the course of the test, the Benchmark Team Leader may periodically brief the key Contractor's staff on the major findings identified. All appropriate Contractor and Benchmark Team personnel will be present to answer any questions raised.

g. At the conclusion of the Benchmark Test an exit conference will be held with the Contractor staff to brief the Contractor on all findings identified during the benchmark. A draft report of the initial test results will be left with the Contractor for review. The initial Benchmark Test report will be forwarded to the Contractor by *TMA* within 45 days of the last day of the test.

h. Within seven (7) days of the last day of the Benchmark Test, the Contractor shall prepare and submit the initial HCSRs submission to the *TMA* , Information Systems Division for evaluation. The Contractor shall be notified of any HCSRs failing the *TMA* edits. The Contractor shall make the necessary corrections and resubmit the HCSRs until 100% of the original Benchmark Test HCSRs have passed the edits and are accepted by *TMA*.

i. The Contractor has 45 days from the date of the initial Benchmark Test report to submit to *TMA* the corrected claims and HCSRs. For any claims processing errors assessed with which the Contractor disagrees, a written description of the disagreement along with any specific references should be included with the corrected claims.

j. While new HCSRs need not be generated to reflect changes created from claims processing corrections, all HCSRs originally submitted for the Benchmark Test claims which did not pass the *TRICARE Management Activity (TMA)* edits must continue to be corrected and resubmitted until all edit errors have been resolved and 100% of the HCSRs have been accepted by *TMA*.

4. Operational Aspects

a. The Benchmark Test may be conducted on the Contractor's production system or an identical copy of the production system (test system). Whichever system is used for the benchmark, it must meet all TRICARE requirements and contain all the features proposed for the production system in the Contractor's proposal.

b. When the benchmark is conducted on the Contractor's production system, a mechanism must be available to prevent checks and EOBs from being

mailed to the beneficiaries and providers, and to prevent production payment records from being generated and sent to *TMA*.

c. The DEERS and CDCF test systems are integral components of the Benchmark Test and the Contractor is expected to perform all necessary verifications, queries, etc. to these systems according to TRICARE procedures and policy. The Contractor will be required to access test files established for the Benchmark Test. The Contractor shall coordinate through the *TMA*, Contractor Evaluation Branch, for direct interface with DEERS and the *TMA* ADP Contractor to ensure that linkage with DEERS and the CDCF files is established and operational prior to the Benchmark Test.

d. HCSRs shall be generated from the Benchmark Test claims and provided to *TMA* for processing as scheduled at the pre-benchmark meeting. The Contractor shall coordinate through the *TMA*, Contractor Evaluation Branch, for direct interface with the *TMA*, Information Systems Division, for HCSR submission procedures for the Benchmark Test claims.

F. Discontinuance of MCS Contractor Mail Order Pharmacy Programs

Effective October 6, 1997, the Department of Defense will begin offering a National Mail Order Pharmacy (NMOP) service. The NMOP benefit will be independent of and separate from all other TRICARE benefits and will not be administered by MCS Contractors. Upon notification by the contracting officer, MCS contractors must discontinue any and all separate Mail Order Pharmacy operations which have previously existed in the Regions. The following paragraphs detail the activities which must be undertaken by the MCS contractor in support of the Department's transition to the NMOP program.

1. Phase I

Effective October 6, 1997, the Department of Defense will begin offering a National Mail Order Pharmacy (NMOP) service which will be available to:

a. Active duty beneficiaries,

b. TRICARE beneficiaries residing in Alaska and Puerto Rico;

c. Medical Treatment Facility (MTF) Prime enrollees (Note: these beneficiaries are eligible to use either the MCS mail order pharmacy or the NMOP);

d. Overseas TRICARE beneficiaries listed in DEERS (with APO or FPO addresses);

e. Base Realignment and Closure (BRAC) Medicare eligible beneficiaries in Regions 1, 2, & 5; Adak, AK; Ft. Chaffee, AR; Sierra Army Depot, CA; Naval Branch Clinic, Treasure Island, CA; Naval Branch Clinic, Alameda, CA; and

f. Regions 1, 2, & 5 MTF Primary Care Managed enrollees prior to the start of the managed care contract.

2. Phase II

At a future date as directed by the Contracting Officer, NMOP benefits will also be provided to:

a. BRAC Medicare eligible beneficiaries in Regions other than 1, 2, & 5; Adak, AK; Ft. Chaffee, AR; Sierra Army Depot, CA; Naval Branch Clinic, Treasure Island, CA; Naval Branch Clinic, Alameda, CA; and

b. All beneficiaries now covered by managed care support (MCS) contractors (both enrolled and non-enrolled).

3. General

a. Public Notifications

(1) Upon notification by the contracting officer, the MCS Contractor shall initiate action, using existing information dissemination mechanisms, to notify as many TRICARE beneficiaries as possible of the date for discontinuance of the contractor's mail order pharmacy and the name and address of the NMOP contractor.

(2) These notifications may include but are not limited to:

(a) Inclusion of notices in enrollee, HBA and other currently produced newsletters.

(b) Use of EOB "flash" messages or stuffers.

(c) Addition of messages on recordings played while incoming calls are on hold.

(d) Notices or flyers available to be picked up at the TSCs.

(e) Addition of messages on any existing automated bulletin boards or internet home pages.

(3) MCS Contractors shall not undertake special mailings, install new systems or otherwise initiate new notification mechanisms which do not already exist, solely in support of this NMOP program public notification effort.

b. Data

The NMOP Contractor will utilize only the claims payment history which accrues from their own processing. Therefore, the MCS Contractor will not be required to provide to the NMOP Contractor any information to facilitate transitions from the Contractor's operations to operations under the NMOP contract.

4. Phase-out of Mail Order Pharmacy Operations

The contracting officer will notify MCS contractors of the implementation date of Phase II. The MCS contractor shall cease mail order pharmacy operations as of that date. All new prescriptions and requests for refills postmarked prior to the implementation date of Phase II shall be processed by the MCS contractor. As such actions are completed, beneficiaries shall be notified in writing of the discontinuance of the MCS contractor's Mail Order Pharmacy Program and the implementation of the NMOP Program. (Refer to Figure 1-1-A-6 for a sample notification letter.) All new prescriptions postmarked on or after the implementation date of Phase II shall be forwarded within forty-eight (48) hours of receipt to the NMOP contractor for processing, with written notice to the

beneficiary that the prescription has been forwarded. Requests for refills received after the implementation date shall be returned to the beneficiary with direction to obtain a new prescription and send it to the NMOP contractor. Prescriptions received more than ninety (90) calendar days after the implementation date of Phase II shall be returned to the beneficiary with direction to send the prescription to the NMOP contractor. (Refer to Figure 1-1-A-4 and Figure 1-1-A-5 for sample notification letters.)

5. MCS Contractor Weekly Status Reporting

Upon direction of the contracting officer, and continuing until all pending claims for mail order pharmacy services have been processed to disposition, the MCS Contractor shall submit to *TMA*, Chief, Managed Care Support Operations Branch, a weekly status report of mail order pharmacy prescription inventories.

6. Correction of Edit Rejects

The MCS Contractor shall remain responsible for correction (and reprocessing through *TMA*) of all mail order pharmacy health care service record edit errors resulting from their processing of the initial claims.

7. Application of Catastrophic Loss Protection Provisions Under the NMOP

Until such time as the NMOP Contractor has implemented an automated interface with the centralized repositories of catastrophic cap data (the CDCF, the MCS Contractors' Enrollment Year Catastrophic Cap files, or their successor files), they will process all claims and apply appropriate cost shares under an assumption that catastrophic cap thresholds have not been met. However, if a beneficiary specifically affirms to the NMOP Contractor that the catastrophic cap thresholds have been met, the NMOP Contractor will not apply deductibles or cost shares. Some beneficiaries may choose to provide documentation to the NMOP Contractor, in the form of a EOB, to establish that the catastrophic cap has been met. MCS Contractors shall comply with all beneficiary requests for copies of EOBs in support of this requirement.

8. Coordination of Benefits under the NMOP

The NMOP Contractor will have no Other Health Insurance (OHI) coordination of benefit responsibilities other than an initial screening for a declaration that pharmacy coverage under OHI is or is not available. Beneficiaries who have pharmacy coverage under OHI will be required to utilize their other available pharmacy coverage and their prescriptions will be returned unfilled. TRICARE will remain available as second payer under applicable double coverage rules. When future DEERS upgrades permit access to OHI pharmacy coverage information, the NMOP Contractor will be required to utilize that information in their processing.

9. Freedom of Choice and Availability of Benefits

Beneficiaries are not required to utilize the NMOP mechanism. At their discretion, they may continue to use TRICARE network or non-network retail pharmacy providers to the extent that they are permitted to do so under their existing TRICARE coverage. Similarly, if the drug which has been prescribed is not in the NMOP formulary, it may still be covered under TRICARE, subject to normal TRICARE coverage rules. Overseas Prime enrollees listed as such on DEERS may utilize the NMOP program provided the

pharmaceuticals are mailed to an address within the United States, including APO or FPO addresses.

Claims Processing Procedures

Table of Contents

Table of Contents

Table of Contents

Table of Contents